AIR COMMAND AND STAFF COLLEGE

STUDENT REPORT

MEETING THE COMBAT STRESS CHALLENGE:
SPECIAL PSYCHOLOGICAL INTERVENTION
AND REINTEGRATION TEAMS (SPIRITs)

MAJOR DAVID L. HERRES 88-1205

"insights into tomorrow"

DISCLAIMER

The views and conclusions expressed in this document are those of the author. They are not intended and should not be thought to represent official ideas, attitudes, or policies of any agency of the United States Government. The author has not had special access to official information or ideas and has employed only open-source material available to any writer on this subject.

This document is the property of the United States Government. It is available for distribution to the general public. A loan copy of the document may be obtained from the Air University Interlibrary Loan Service (AUL/LDEX, Maxwell AFB, Alabama, 36112-5564) or the Defense Technical Information Center. Request must include the author's name and complete title of the study.

This document may be reproduced for use in other research reports or educational pursuits contingent upon the following stipulations:

- Reproduction rights do not extend to any copyrighted material that may be contained in the research report.

- All reproduced copies must contain the following credit line: "Reprinted by permission of the Air Command and Staff College."

- All reproduced copies must contain the name(s) of the report's author(s).

- If format modification is necessary to better serve the user's needs, adjustments may be made to this report--this authorization does not extend to copyrighted information or material. The following statement must accompany the modified document: "Adapted from Air Command and Staff College Research Report (number) entitled (title) by (author)."

- This notice must be included with any reproduced or adapted portions of this document.

REPORT NUMBER 88-1205

TITLE MEETING THE COMBAT STRESS CHALLENGE: SPECIAL PSYCHOLOGICAL INTERVENTION AND REINTEGRATION TEAMS (SPIRITs)

AUTHOR(S) MAJOR DAVID L. HERRES, USAF, BSC

FACULTY ADVISOR CHAPLAIN, LT COL, DAVID W. FAHNER, USAF, ACSC/HC

SPONSOR LT COL FRANK L. GOLDSTEIN, USAF, BSC
DIRECTOR, JOINT PSYCHOLOGICAL OPERATIONS COURSE
HURLBURT FIELD, FL 32544

Submitted to the faculty in partial fulfillment of requirements for graduation.

AIR COMMAND AND STAFF COLLEGE
AIR UNIVERSITY
MAXWELL AFB, AL 36112-5542

UNCLASSIFIED
SECURITY CLASSIFICATION OF THIS PAGE

A192 456

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION UNCLASSIFIED	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION/AVAILABILITY OF REPORT STATEMENT "A" Approved for public release; Distribution is unlimited.
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S) 88-1205	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION ACSC/EDCC 6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) Maxwell AFB AL 36112-5542	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING/SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
MEETING THE COMBAT STRESS CHALLENGE: SPECIAL PSYCHOLOGICAL INTERVENTION AND REINTEGRATION TEAMS (SPIRITs)

12. PERSONAL AUTHOR(S)
HERRES, DAVID L., MAJOR, USAF, BSC

13a. TYPE OF REPORT	13b. TIME COVERED FROM _____ TO _____	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
		1988 April	

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

Military medical history, at least since World War I, consistently points out that the successful management and treatment of combat-related stress disorders depends directly on timely, supportive therapy--provided as close to the battlefront as logistically possible. Regrettably, AF Military Treatment Facilities (MTF) don't have standardized wartime plans for establishing forward-based psychiatric intervention teams at the second echelon of medical care.

This research project explores the need for AF medical facilities to develop a standardized operational plan that provides guidance for establishing forward-based psychiatric intervention teams. In addition, this report provides basic guidelines for developing (S)pecial (P)sychological (I)ntervention and (R)e(I)ntegration (T)eams (SPIRITs) near the wartime second echelon (2E) treatment facility.

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT ☐ UNCLASSIFIED/UNLIMITED ☒ SAME AS RPT. ☐ DTIC USERS	21. ABSTRACT SECURITY CLASSIFICATION UNCLASSIFIED
22a. NAME OF RESPONSIBLE INDIVIDUAL ACSC/EDCC Maxwell AFB AL 36112-5542	22b. TELEPHONE (Include Area Code) (205) 293-2483 22c. OFFICE SYMBOL

DD Form 1473, JUN 86 *Previous editions are obsolete.*

SECURITY CLASSIFICATION OF THIS PAGE
UNCLASSIFIED

PREFACE

Military medical history, at least since World War I, consistently points out that the successful management and treatment of combat-related stress disorders depends directly on timely, supportive therapy--provided as close to the battlefront as logistically possible. Regrettably, Air Force Military Treatment Facilities (MTF) don't have standardized wartime plans for establishing forward-based psychiatric intervention teams at the second echelon of care. Moreover, the effective and timely establishment and deployment of such teams would require considerable time, training, and costs--all at the expense of the fighting force.

In addition, current USAF Medical Wartime Readiness Planners haven't clearly defined nor agreed upon the proper clinical roles for the primary mental health professionals directly responsible for managing and treating the combat-stressed airman. For example, USAF medical planners haven't clearly identified or delineated the wartime clinical roles Air Force clinical social workers are capable of providing at the second echelon medical facility. In view of the social work manpower strength (207 out of 529 total mental health officers), this omission has created significant problems in terms of preparing and training for war.

This research project explores the need for Air Force medical facilities to develop a standardized operational plan that provides guidance for establishing forward-based psychiatric intervention teams. In addition, this report provides basic guidelines for establishing (S)pecial (P)sychological (I)ntervention and (R)e(I)ntegration (T)eams (SPIRIT) near the wartime second echelon (2E) medical treatment facility. Finally, this study will recommend that all mental health officer SPIRIT members mutually share most fundamental medical roles and responsibilities during the SPIRIT's activation.

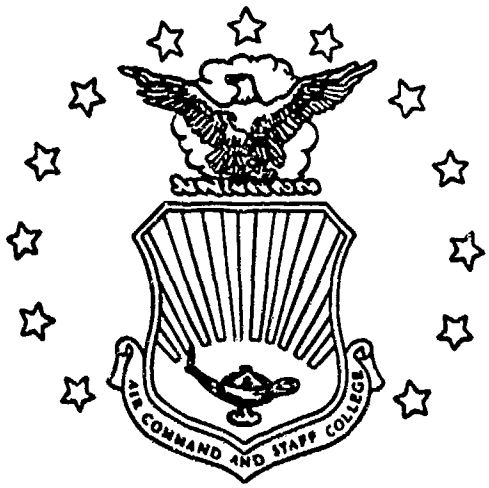
The author wishes to acknowledge the following individuals for their tireless efforts at proofreading, editing, and providing constructive advice during the preparation of this project: Colonel David R. Jones, USAF (Ret.); Colonel Royden W. Marsh, USAF; Colonel Gregory L. Belenky, USA; Colonel James Stokes, USA; Lt Col Frank L. Goldstein, USAF; Captain Michael H. Kettering, USAF; and Captain Peter R. Faber, USAF.

ABOUT THE AUTHOR

Major David L. Herres was commissioned in July 1978 through the United States Air Force Biomedical Science Corps' direct appointment program. Throughout his career he has served as a clinical social worker and education staff officer at base and major command levels. His first assignment was to Laughlin AFB, Texas where he served as Chief of the Mental Health Clinic. In 1982, Major Herres was assigned to Incirlik AB Hospital where he served as a staff social worker. Major Herres was then assigned to Squadron Officer School in 1984 where he served as a section commander, curriculum manager, and Chief of the Leadership Branch. He holds a bachelor of arts degree in psychology and a master's of social work from the University of South Carolina. He is also a licensed clinical social worker in Alabama and South Carolina. Major Herres completed Squadron Officer School in 1982. His decorations include the Meritorious Service Medal and the Air Force Commendation Medal with one oak leaf cluster.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS



EXECUTIVE SUMMARY

Part of our College mission is distribution of the students' problem solving products to DOD sponsors and other interested agencies to enhance insight into contemporary, defense related issues. While the College has accepted this product as meeting academic requirements for graduation, the views and opinions expressed or implied are solely those of the author and should not be construed as carrying official sanction.

"insights into tomorrow"

REPORT NUMBER 88-1205

AUTHOR(S) MAJOR DAVID L. HERRES, USAF, BSC

TITLE MEETING THE COMBAT STRESS CHALLENGE: SPECIAL PSYCHOLOGICAL INTERVENTION AND REINTEGRATION TEAMS (SPIRITs)

I. Purpose: To provide the Joint Psychological Operations Branch, USAF Special Operations School (MAC), Hurlburt Field (USAF Special Operations School/EDOP) with information for their use in developing a standardized operational plan that provides guidelines for establishing forward-based psychiatric intervention teams. Information in this analysis is intended to assist mental health officers enhance their knowledge of combat-related stress disorders, understand their roles in its treatment, and how to implement a forward-based psychiatric intervention team.

II. Objectives: To document the need for Air Force Medical Facilities (MTF) to establish standardized wartime plans that include guidelines for organizing and developing (S)pecial (P)sychological (I)ntervention and (R)e(I)ntegration (T)eams (SPIRIT). To provide mental health officers with general guidelines for establishing SPIRITs.

III. Findings: Military medical history, at least since World War I, consistently points out that the successful management of combat-related

stress disorders depends directly on timely, supportive therapy--provided as close to the battlefront as logistically possible. Air Force medical facilities (MTF) don't have standardized operational plans for providing forward-based psychiatric intervention teams near the second echelon medical facility. Moreover, the effective and timely establishment and deployment of such teams would require considerable time, training, and costs--all at the expense of the fighting force. Furthermore, USAF medical planners haven't clearly defined nor agreed upon the proper clinical roles for the primary mental health professionals directly responsible for managing the combat-stressed airman.

Combat-related stress reactions involve a range of physical and emotional responses to intense fear and uncertainty about one's survival during combat or in support of combat operations. In contrast to the traditional understanding of mental illness, in which the psychiatric disorder is prolonged or life-long, combat-related stress disorders typically involve three phrases: (1) an onset phase (acute, intensive stress), (2) an emotional and physical breakdown period (ineffective coping, psychosomatic responses, and ineffective duty performance), and (3) a recovery stage, usually within 3-4 days after supportive therapy begins. When an airman's behavior deteriorates to ineffective duty performance and he misses 24 hours of duty because of dysfunctional behavior, medical authorities identify that airman as a psychiatric casualty. Since the psychiatric casualty can be a serious risk, both to himself and others, combat leaders traditionally have removed him from combat duty. Through the years of war experience, however, medical practitioners learned that the psychiatric casualty need not be an unavoidable cost of war. Instead, he represents a salvageable fighting resource. In fact, military medical history clearly points out that 50 to 80 percent of those troops suffering from combat stress reactions can be returned to full duty within 72 hours after medics begin supportive therapy.

V. Conclusions: Combat psychiatric casualties are not unavoidable costs of war. Instead, they represent a salvageable manpower resource. Medical practitioners can return 50 to 80 percent of those troops suffering from combat stress disorders within 72 hours after supportive therapy begins. Through the years of war experience, the Air Force military medical community learned that the best intervention programs involved treating the psychiatric casualty using the BICEPS treatment regimen: Medical practitioners should treat (B)riefly, with (I)mmediacy, in a (C)entral location, with an (E)xpectancy that the troop will return to full duty, in (P)roximate location to the individual's unit, and with (S)imple supportive therapy.

VI. Recommendations: According to the author's survey of all Air Force clinical social workers, medical treatment facilities need a standardized operational plan outlining how to establish a forward-based

psychiatric intervention team. Based upon the survey results and the historical success of forward-based intervention teams, the author recommends establishing Air Force-wide, standardized Special Psychological Intervention and Reintegration Teams (SPIRIT) at all Air Force medical facilities. Finally, the author recommends that the mental health officer (SPIRIT) members mutually share most clinical and administrative duties and responsibilities during the SPIRIT's activation.

Chapter One

INTRODUCTION

Beside us lies a fair-headed recruit in utter terror. He has buried his face in his hands, his helmet has fallen off. I fetch hold of it and try to put it back on his head. He looks up, pushes the helmet off and like a child creeps under my arm, his head close to my breast. The little shoulders heave. Shoulders just like Kimmerick's. I let him be. So that the helmet should be of some use I stick it on his behind;--not for a jest, but out of consideration, since that is the highest part. And though there is plenty of meat there, a shot in it can be damned painful. Besides, a man has to lie on his belly in the hospital, and afterward he would be almost sure to have a limp.

It's got someone pretty badly. Cries are heard between the explosions.

At last it grows quiet. The fire has lifted over us and now is dropping on the reserves. We risk a look. Red rockets shoot up in the sky. Apparently there's an attack coming.

Where we are it is still quiet. I sit up and shake the recruit by the shoulder. "All over, kid! It's all right this time."

He looks around dazedly. "You'll get used to it soon," I tell him.

He sees his helmet and puts it on. Gradually he comes to. Then suddenly he turns fiery red and looks confused. Cautiously he reaches his hands to his behind and looks at me dismally.

I understand at once: Gun-shy. That wasn't the reason I had stuck his helmet over it. "That's no disgrace," I reassure him: "Many's the man before you has had his pants full after the first bombardment. Go behind that bush there and throw your underpants away. Get along-"

-- All Quiet On the Western Front
Erich Maria Remarque (2:40)

With some humor, yet profound dignity and truth, Erich Remarque captures a World War I soldier's intense emotional and physical reaction to the terrors of war--terrors so intense that loss of bodily functions become a common occurrence in the face of battle. Moreover, Remarque's story provides a simple yet poignant example of what military medical practitioners now diagnose as a combat-related stress reaction.

Described and defined in another way, combat-related stress reactions involve a range of physical and emotional responses to intense fear and uncertainty about one's survival during combat or in support of combat operations (17:--). In contrast to the traditional understanding of mental illness, in which the psychiatric disorder is prolonged or life-long, combat-related stress reactions typically involve three phases: (1) an onset phase (acute, intensive stress), (2) an emotional and physical breakdown period (ineffective coping, psychosomatic responses, and ineffective duty performance), and (3) a recovery stage, usually within 3-4 days after rest and supportive therapy begins (16:--). When a soldier's behavior deteriorates to the point of ineffective duty performance and he misses 24 hours of duty because of dysfunctional behavior, medical authorities identify that soldier as a psychiatric casualty (4:338). Since the psychiatric casualty can be a serious combat risk, both to himself and others, combat leaders traditionally have removed him from the battle area (17:--). Through years of war experience, however, medical practitioners learned that the psychiatric casualty need not be an unavoidable cost of war. Instead, he represents a salvageable fighting resource (8:20). In fact, military medical history clearly points out that we can return from 50 to 80 percent of those soldiers suffering from battle fatigue or combat exhaustion to full duty (typically within 72 hours) after medics initiate supportive therapy (17:--).

Chapter Two

COMBAT STRESS: HISTORIC OVERVIEW AND LESSONS LEARNED

In the past, both commanders and medical personnel have confused a combat-stress breakdown with mental illness (8:20). For example, US Army researchers Majors Larry Ingraham and Frederick Manning ". . . routinely observed simulations of combat-related stress reactions in army field training exercises portrayed as comedy routines." Ingraham and Manning note:

> The role playing patients babble incoherently, get violent, and are physically strapped between two litters and hustled from the field to the merriment of all. Real combat stress patients seldom act this way. The confusion between stress reactions and mental illness, however, is understandable in view of the history of the syndrome (8:20).

WORLD WAR I

During World War I, military surgeons first used the term "shell shock" to diagnose psychiatric casualties (8:20). After periods of intense battle and chronic stress, some soldiers were dazed, tremulous, confused, blind, deaf, or paralyzed for no apparent neurological reason (8:20). Medical authorities assumed these symptoms resulted from internal head injuries, which often were irreversible. Little was done to treat soldiers and get them back to the battlefront. Commanders and medical officers agreed, ". . . the manpower loss due to shell shock was an unavoidable cost of war" (8:20).

"Later in the war, it became clear that 'shell shock' was a psychological condition" (8:20). Physicians observed marked physical and emotional improvement among "shell shock" patients after their commanders removed them from the battlefront and the acute stress of battle. As a result, practitioners changed their diagnosis of "shell shock" to "war neurosis" (8:20). The change in diagnostic classification helped physicians develop a greater understanding and appreciation that "war neurosis" involved a wide range of physical and emotional symptoms (5:725). As the intensity of the war escalated, increasing numbers of soldiers experienced loss of breath, anxiety, irritability, confusion, tearfulness, sleep loss, and panic. These physical and emotional difficulties gradually led to ineffective duty performance and suspension from combat positions.

"Although military surgeons identified combat-related stress disorders prior to World War I, their great frequency during this conflict provoked the first serious medical efforts to salvage the large manpower loss" (5:725). Glass notes:

> Physicians developed effective medical management of the psychiatric casualty by using the trial and error method. Early in World War I, French and British medical services became aware that the proximity and immediacy of medical treatment was critical for successful therapy outcomes. They learned that when psychiatric casualties were evacuated to rear hospitals, resistance to treatment was the rule; symptoms became fixed and often chronic disability resulted. This was in sharp contrast to treatment results obtained near the battlefront, where physicians restored 60-75% of acute battle stress patients to full duty by therapy not exceeding 7 days (5:725).

Practitioners realized they could get good results by simple treatment methods that included rest, food, encouragement, suggestion, and persuasion. Thus, the British and French war neuroses experience established a foundation for future medical treatment plans that practitioners used during World War II, Korea, and Vietnam.

Early in World War I, American medical services were aware of the French and British success in treating the psychiatric casualty. As a result, American surgeons applied the principle of "forward psychiatric treatment" (5:725). "Logistic difficulties hindered their early efforts, but they made steady progress towards instituting an effective psychiatric program" (5:725). Glass notes:

> In the latter months of the war the program contained three levels of treatment: (1) therapy for mild cases in the combat zone by division psychiatrists; (2) close support for psychiatric evacuees from the combat zone by provisional neurological hospitals, situated at field army level; and (3) special neuropsychiatric base hospitals, located in the rear where treatment was prolonged and extensive (5:725).

Essentially, American psychiatrists confirmed and extended the concepts the French and British established. Allied medical authorities now considered war neurosis to be a psychological condition, and they discarded the physical explanations associated with the term "shell shock" (5:725). Glass explains:

> The medical community's ideas were supported by the following facts: (1) war neuroses was rare among the wounded and prisoners who were exposed to the same explosions, (2) patients who had severe brain and spinal cord injuries did not show the same range of emotional behavior exhibited by "shell shock" patients, and (3) "shell shock" patients recovered

rapidly following brief psychological therapy at the front line (5:725).

After much trial and error, American, French, and British medical authorities all agreed that war neurosis provided soldiers with an escape from an intolerable situation. In addition, they saw mental breakdown in combat as the result of the soldier's inability to cope: the defense mechanisms that sustain the soldier during intensive stress fall apart. Glass points out, "Resistance mechanisms included individual personality traits, physical health, group loyalty, and leadership" (5:726). Unfortunately, the lessons learned and the effective treatment foundation established during World War I weren't carried over into World War II.

WORLD WAR II

With the onset of World War II, American medical services were not prepared to use the successful treatment principles of "forward-based psychiatric therapy" used during World War I (5:726). In fact, ". . . psychiatrists were no longer assigned to combat divisions and there were no provisions made for special psychiatric treatment units at the field army level" (5:726). Specific reasons for the deficiencies were unclear, but commanders seemingly thought war neuroses were unique to the trench warfare tactics of World War I. Such short-sightedness cost us: the first large-scale land fighting by American troops, during the 1942-43 Tunisian campaign, produced large numbers of psychiatric casualties. Initially, as in World War I, the Army evacuated and treated these soldiers hundreds of miles away from the battlefront. And again, medical evacuation created significant short- and long-term problems for patients and the military. First, rear-based hospitals were unprepared for a large, immediate influx of psychiatric patients. Second, timely psychiatric care was scarce, and delayed treatment only fixed symptoms, not causes. In fact, the Army eventually shipped many of these soldiers back to the United States with chronic psychiatric disabilities and they never returned to their combat units (5:726). Finally, evacuation significantly reduced fighting manpower. Ingraham and Manning illustrate the point:

> In ten days of fighting on Okinawa, the 6th Marine Division received 2,662 wounded in action (WIA) and sustained an additional 1,289 (48 percent of the WIA) psychiatric casualties. In 44 days on the Gothic Line, the 1st Armored Division sustained 250 WIA with 137 psychiatric casualties (54 percent). At the same time and place, the 91st Division suffered 2,700 WIA and 919 additional psychiatric casualties (34 percent) (8:19).

The significant loss of manpower consequently forced commanders and medical personnel to re-establish the proven "forward-based psychiatric treatment" methods previously used during World War I. As a result, ". . . in the Spring of 1943, Doctors F. Hanson and L. Tureen, working

at a forward evacuation hospital with fresh psychiatric casualties, applied the treatment principles established in World War I" (5:276). Using short-term supportive therapy and providing patients with rest, food, and sleep, they were able to return ". . . 50% of their patients to combat duty within 4 days and thus restored the value of the treatment methods developed in World War I" (5:276).

KOREA

When the Korean War started, ". . . the Army didn't forget the lessons of combat psychiatry learned during World War I and II" (5:729). Army regulations, training manuals, and other official publications incorporated the well-proven forward-based treatment principles developed in the preceding wars. In fact, soon after the outbreak of conflict in June 1950, "Army psychiatry became operational within 6-8 weeks" (5:729). By October 1950, the Army established three levels of psychiatric treatment--not only duplicating the treatment principles of World Wars I and II, but fine-tuning treatment methods. According to Glass, "It had long been suspected that the simple techniques of forward treatment could be adequately performed by general medical officers, instead of psychiatrists--if they were properly trained" (5:729). As a result, by December 1950 general medical practitioners were providing successful psychiatric care to combat-stressed soldiers. The benefits of this innovation were obvious. Glass summarizes:

> First, the number of soldiers returned to duty within 24-48 hours increased after practitioners evaluated and treated them at the battle aid station. Second, the innovation alleviated some of the anxiety soldiers experienced when the Army evacuated them to regimental collection points--away from their units and combat buddies. Finally, using general medical practitioners allowed army psychiatrists more time to move from battalion aid stations to regimental collection points and provide instruction and consultation (5:729).

Another significant treatment development during the Korean War was reclaiming for combat duty those soldiers who the Army evacuated and reassigned to non-combat positions in Japan earlier in the war (5:730). The Army re-evaluated all such cases after 3 months to see who was fit to return to combat duty. Glass notes that ". . . 40% of these soldiers were indeed returned to their units and the success with soldiers in this status seemed to hinge on their desire to regain lost self-esteem associated with their initial evacuation from combat" (5:730).

VIETNAM

Doctor Peter G. Bourne, Chief of the Neuropsychiatry Section, U.S. Army Research Team, during the Vietnam conflict notes:

> With the advent of the Vietnam conflict there was every reason to believe the incidence of psychiatric casualties would be high. The physically demanding conditions of jungle warfare, an elusive enemy, and the absence of well-defined battlefronts all suggested that the stress on the individual soldier would be intense. However the most significant finding of the war had been that the number of psychiatric casualties remained quite low. The incidence of psychiatric problems requiring hospitalization remained the same as that of a comparable stateside force. Many of those seen by psychiatrists in Vietnam had problems unrelated to combat. The bulk of cases came from the combat support units instead of those actually involved in combat (3:125).

Although the reasons for the low level of psychiatric casualties are multiple, the psychological awareness of the command leadership was a primary influence (3:125). Command planning for the Vietnam War took into account many of the factors known to increase psychiatric casualties. Commanders placed an emphasis on better training, equipment, leadership, and rapid medical evacuation. They tried to provide soldiers with hot meals flown in by helicopters, and they withdrew units engaged in prolonged, intense battles to rear areas for follow-on rest and relaxation (3:125). In addition to command leadership innovations, the style of war in Vietnam involved brief battles and mobility. Only in few cases did the enemy subject U.S. soldiers to prolonged bombardment in fixed defensive positions, as was common in previous wars. Above all, a primary factor influencing the low level of psychiatric casualties was the one-year tour (3:125). Bourne notes, "Soldiers knew if they could survive one year of combat, then they would go home. In contrast to previous wars, soldiers generally didn't feel the hopelessness found in a war where death, injury, or an arranged peace were the only ways to escape combat" (3:125). Bourne also points out that the rest and relaxation program (R&R) contributed to low psychiatric casualties rates. During a soldier's Vietnam tour he could spend a one-week vacation in one of the surrounding countries of Southeast Asia. Soldiers generally took their vacations at the six-month point, and this R&R period represented to them a significant milestone of their tour.

Although command leaders took many steps to minimize combat-related stresses, the Vietnam War did produce significant numbers of psychiatric casualties. The Medical Statistics Agency of the Army Surgeon General's Office recorded statistics for the five-year period between 1965-1970 (4:338) (see Table 1, next page). What's significant in these figures are the overall low psychiatric casualty rates as compared to previous wars. Combat area rates in World War II ranged from a high of 101 per 1000 troops per year (First U.S. Army, Europe) to a low of 28 per 1000 troops per year (Ninth U.S. Army, Europe). The Korean War rates from July 1950 to December 1952 were 37 per 1000 troops per year (4:338).

US Army Doctors Edward M. Colbach and Matthew D. Parrish conclude that ". . . not only did the preventive measures introduced by senior leaders help reduce combat-related stress, but they argue that other

1965	10.8 per 1000 troops per year
1966	11.5 per 1000 troops per year
1967	9.8 per 1000 troops per year
1968	12.7 per 1000 troops per year
1969	15.0 per 1000 troops per year
1970	24.1 per 1000 troops per year

Table 1. Vietnam War Psychiatric Casualty Rates (1965-1970)

factors also reduced the number of psychiatric casualties" (4:339). They point out that ". . . the U.S. had clear superiority in both air and sea, supplies were plentiful, and communications were excellent. In addition, American soldiers had higher education levels and were better trained and better led than ever before" (4:339). Dr. David R. Jones notes that ". . . strong cohesive units develop when commanders direct leadership efforts toward building morale, discipline, and loyalty. Then when troops maintain unit cohesion, their combat stress tolerance levels will increase" (17:--). In short, soldiers are better prepared individually to manage the intense stresses of war. In Vietnam, despite general impressions, soldiers did handle the stress of war better than in the past (4:339).

LESSON LEARNED

Through the years of war experience, the military medical community and senior military leaders gradually began working together and applying the lessons learned from previous wars. As a result, commanders and medical officers learned new ways to prevent, identify, and successfully treat the psychiatric casualty.

Today, senior military leaders have begun to recognize the fact that the psychiatric casualty is an inevitable product of armed conflict and that the subsequent loss of manpower associated with combat-related stress disorders represents a salvageable resource. In particular, the Vietnam experience demonstrated that not only is the combat troop vulnerable to stress reactions, but troops in noncombatant support roles are also vulnerable to the intense stresses of war.

Through trial and error, medical practitioners also learned that they obtained best treatment results when working with the psychiatric casualty close to the battlefront, and soon after the soldier exhibits signs of mental and physical exhaustion. Practitioners also achieved good results with simple supportive measures such as rest, relaxation, food, and encouragement, and with an "expectancy" that the soldier would fully recover and return to his combat unit within 48 to 72 hours.

Today, Air Force medical officers continue refining the treatment principles laid down since World War I. In particular, the Air Force recognizes an optimum treatment regime identified by the acronym known as "BICEPS". Coined in 1981 by Colonel (Dr) David R. Jones, each letter represents one of the six treatment principles laid down by U.S. Army psychiatrists since 1917 (11:2). Jones summarizes BICEPS as: (B)revity, (I)mmediacy, (C)entrality, (E)xpectancy, (P)roximity, and (S)implicity.

Finally, the Korean and Vietnam Wars demonstrated that the most significant lesson learned involved "preventing" psychiatric casualties. The low psychiatric casualty rates during both wars were attributable to such preventive measures as: (1) building strong unit cohesion within combat and noncombat units, (2) ensuring unit leadership was effective, (3) maintaining durable unit morale and loyalty, (4) providing timely rest and relaxation periods, and (5) reassigning soldiers to noncombat assignments after a 12-month combat tour. These measures, among others, represent preventive steps commanders effectively used during the Vietnam War. They also represent the proven foundation current commanders and medical planners need to build upon while preparing for future conflicts and developing intervention programs to maintain troop strength.

Chapter Three

GENERAL DESCRIPTION OF THE USAF FIVE-ECHELON MEDICAL CARE SYSTEM

"The Air Force Medical Services wartime mission is to provide participating forces with the medical support necessary to maintain the highest degree of combat readiness and effectiveness" (9:6-1). In order to provide timely, effective, and efficient medical care to troops wounded in combat, current U.S. Air Force Wartime Operational Plans call for establishing a five-echelon care system (19:--). Specifically, the A.F. Medical Service will organize and implement five levels of medical care ranging from simply first-aid treatment at the battlefront to comprehensive rehabilitation in major medical centers in the United States. An "echelon of care" is best described as a flexible, mobile health care structure. It may consist of a medical station or facility established at predesignated areas starting near the battlefront to as far away as a medical center in the United States (17:--). "Medical functions at each level will expand or contract depending on specific needs, numbers of wounded, and the unpredictable wartime environment. Also, one or more of the echelons may be bypassed or combined for greater effectiveness and efficiency" (10:6-4). Medical practitioners located throughout the second through fifth echelons of care will provide increasingly more specialized and definitive treatment, depending on the severity of the injury.

Presently, Medical Operational Plans locate the first echelon (1E) of care near the site of an air attack against U.S. Air Forces (17:--). Jones notes, ". . . enemy forces will likely concentrate their air power against air base runways, maintenance areas, and fuel storage tanks" (17:--). Here, a wounded airman will provide first aid to himself, or his combat buddies will provide it (7:10). Self-treatment or buddy care may include administering a nerve agent antidote, controlling excessive bleeding, protecting the wound, and (if required) getting the wounded airman to the nearest casualty collection point for evacuation to a higher echelon of care (10:6-4).

Operational Plans then locate the second echelon (2E) of care, housed in tent shelters or other temporary structures, approximately two to four miles from the bombed area (6:25). Medical officers, responsible for treating and evacuating wounded airmen brought from the attacked area, staff the 2E facility. The 2E site is the first level of care in which the wounded airman is directly evaluated by physicians. Here, medical personnel will initially "triage" the incoming wounded (assign priorities of treatment based on the urgency of the injury).

Practitioners will also provide emergency care such as administering intravenous fluid, controlling bleeding, establishing airways for those having trouble breathing, and protecting wounds (10:6-5). Once the wounded airman is physically stabilized, and depending on the severity of his wound, he will either be returned to his unit or evacuated to the third echelon (3E) level of care.

The 3E level of care is now located approximately 20 miles from the bombed area in more permanent or hardened facilities (6:25). The 3E facility is the first medical structure staffed with physicians and equipped to provide limited specialty care. Medical planners consider the care provided here as an extension of field medical care, directed toward saving lives and stabilizing the wounded for evacuation to the fourth echelon of care (10:6-5). In areas containing large concentrations of Air Force personnel, the 3E level of care will be in field hospitals. "With small concentrations of wounded Air Force personnel, the air transportable hospital (ATH) may serve as the 3E facility or as a combined 2E/3E facility" (10:6-5). After physicians stabilize wounded airmen at the 3E level, those who require further medical treatment will be evacuated to the fourth echelon (4E) of care.

The 4E facility, capable of providing comprehensive care, is situated hundreds of miles from the attacked area (6:25). Practitioners will retain patients at the 4E facility throughout their recovery phase if such rehabilitation is possible. If not, medical officers will evacuate wounded airmen to the fifth echelon (5E) of care which is located in the United States (19:--). The fifth echelon (5E) includes major medical centers staffed and equipped to manage the most severely wounded troops.

TREATING THE PSYCHIATRIC CASUALTY AT THE SECOND ECHELON OF CARE

To repeat, military medical history shows that the effective treatment of the psychiatric casualty is directly related to timely, supportive therapy--provided as close to the battlefront as logistically possible. Military medical practitioners define "successful treatment" as returning the psychiatric casualty to duty and thus maintaining troop fighting strength (17:--). Clearly, treating the psychiatric casualty within the second echelon (2E) level of care is the most appropriate setting for successful treatment outcomes. In fact, locating 2E facilities two to four miles from the bombardment area allows practitioners to apply the proven treatment principles of (B)revity, (I)mmediacy, (C)entrality, (E)xpectancy, (P)roximity, and (S)imlicity.

The following section is taken from a 1986 unpublished paper: "Combat Medicine: Stress, Fatigue, Morale, and Leadership," pages 2-18, edited by Major David L. Herres.

BREVITY

Psychiatric treatment in combat should be brief. Jones notes: "A war is not the place for intensive or long-term psychotherapy." Unfortunately, medical officers won't have the luxury to provide "comprehensive" therapy in the precarious, unpredictable war environment. Fortunately, however, history shows that medical officers can return up to 80 percent of the psychiatric casualties within three days.

IMMEDIACY

The psychiatric casualty should be treated as soon as he starts exhibiting signs of mental or physical exhaustion. Commanders and medical practitioners must coordinate closely in order to intervene before symptoms worsen. Treatment should begin as soon as the soldier's symptoms are such that he can no longer support the mission. Clearly, commanders, NCOs, and fellow airmen play an important role in identifying initial fatigue symptoms before, during, and after battle. Moreover, everyone must be sensitive to and aware of "individual" and "overall unit" mental health factors pointing to the onset of combat fatigue.

CENTRALITY

Wartime medical plans should call for treating the psychiatric casualty in one location separate from the hospital. Jones summarizes: "These people are not mentally ill. They are just worn out, which is why we call this condition 'combat fatigue' or 'battle exhaustion'." Through years of war experience, medical officers have succeeded in returning battle-stressed soldiers to their units after short rest periods without hospitalizing these troops. In fact, history shows that if medical practitioners admit psychiatric casualties to hospitals, their symptoms may become fixed, and long-term disabilities may result (5:725). Jones clarifies this point further:

> Putting psychiatric casualties in the hospital reinforces their sick role and may delay recovery. Admission to a military hospital usually begins with putting an unremovable plastic tag on one's wrist, and progresses to having one's clothes put away and being told to wear blue pajamas and lie in a bed in the daytime. Medical personnel are very good at behaving like medical personnel, which elicits patient-like behavior from the recipients of such attention. Our nonverbal behavior reinforces and rewards illness-related behavior on the part of the patients in spite of our verbal reassurances that they are not sick. Instead, they should be kept in uniform, gotten up with reveille, kept out of bed, and kept busy doing whatever is appropriate to the location and situation.

EXPECTANCY

The expectancy principle conveys to the psychiatric casualty the fact that he will recover and subsequently return to duty. Commanders, NCOs, fellow airmen, and attending medical practitioners all must reinforce the fact that the psychiatric casualty "is not sick" and, after a short rest (24-72 hours), will resume his duties. Again, coordination between medical practitioners and commanders is very significant in this effort. If the medical personnel or commanders reinforce the troop's symptoms, those symptoms will worsen and become fixed.

PROXIMITY

Medical practitioners should treat the psychiatric casualty close enough to his unit so that his commander and combat companions can visit him. Visitation helps to maintain the soldier's emotional bonding to his unit--the strongest factor that sustains people in combat. Colonel William C. Porter, a U.S. Army psychiatrist who served as Director of the School of Military Neuropsychiatry at Madison General Hospital, New York, during World War II stated this principle best: "Treat them within the sound of the artillery."

SIMPLICITY

Medical practitioners should keep treatment goal-directed, using rest as the essence of treatment. In addition, medical officers should explain the airman's symptoms to him and reassure him that he is not the first person in the history of war who has had problems with combat. Jones appropriately summarizes:

> Help the soldier understand that he has this syndrome because he is conflicted about being in battle. The conflict is between that part of him that wants to stay and do his duty, and that part of him that says, "I just can't." We must ally ourselves with the part of him that says, "I want to stay and do my duty," and help him to get back to that duty. We must rebuild the defenses against fear that worked for him before he became symptomatic. This differs from the kind of psychotherapy that tears down ineffective defenses and helps build better ones. We are not treating a classic neurosis in this instance, but a normal reaction of normal people to the dreadful stresses of combat.

Medical teams can manage the majority of airmen suffering from combat-related stress disorders at the 2E facility (17:--). On the other hand, some airmen may experience more profound psychiatric disorders and need longer rest periods and special psychological intervention. Such intervention can't be accomplished at the 2E facility. Consequently, practitioners should evacuate these troops to the third

echelon (3E) facility. Here, mental health officers will conduct a more comprehensive examination and implement intensive therapy. After they complete 3E treatment, the mental health officer will re-evaluate the airman for possible return to his unit (7:10). If treatment isn't successful, practitioners will evacuate the airman to the fourth and possibly fifth echelon of care. As troops enter the five levels of care, the primary goal of treatment always remains returning the airman to his unit. Jones states, "When dealing with combat fatigue, getting well means returning to duty and that's all there is to it. Commanders and medical officers must allow no other goal; in this effort, commanders and medical officers will maintain troop strength."

Chapter Four

BRIEF SUMMARY OF U.S. AIR FORCE COMBAT CRISIS INTERVENTION PROGRAMS, CAPABILITIES, AND FUTURE TRAINING NEEDS

QUESTIONNAIRE PURPOSE AND DESCRIPTION

Between 24 June - 24 August 1987, the author mailed questionnaires to all (207) USAF clinical social work officers (See Appendix). The purpose of the questionnaire was to gather information about current Air Force hospital programs, plans, and medical teams already established to prevent, identify, and manage combat-related stress disorders. In addition, the survey solicited data about specific medical operating instructions and current and future training needs. Finally, the survey provided Air Force social workers an opportunity to recommend ideas for developing new combat crisis intervention teams.

The questionnaire consisted of 26 open-ended questions. Since clinical social workers represent almost 40 percent of all mental health officers in the Air Force (207 out of 529), the author surveyed only social workers. The author believes the questionnaire population has adequate knowledge of Air Force crisis intervention programs and provides this research project with an accurate picture of current programs and readiness capabilities. In addition, the population represents first lieutenant through colonel grade levels representing all command levels. Finally, the author tabulated the results and computed a percentage value for each question. Of the 207 officers who were sent a questionnaire, 127 responded. This respondent return-rate represents 61.3% of the total population surveyed and yields a confidence level of 94% (14:24).

QUESTIONNAIRE RESULTS

For the purpose of addressing significant findings, the questionnaire data can be divided into three parts: (1) information about established AF combat crisis intervention teams and training exercises, (2) information about AF social workers' perceived capabilities to manage combat-related stress disorders, and (3) information about future training and readiness considerations.

AIR FORCE CRISIS INTERVENTION TEAMS: ESTABLISHED TEAMS AND TRAINING

Part one of the questionnaire sought to derive information about current crisis intervention teams (see Table 2). Out of 127 responses, 45 respondents reported that their medical treatment facility (MTF) had established a combat crisis intervention team. In addition, only 20.4% noted that their medical treatment facility had published operating instructions providing operational guidance for combat crisis intervention teams. Finally, training frequency and realism appear to be problematic. Only 26.7% of the teams activate their team during

	Frequency of Response	Percent of Total Responses
Total.....	127	100%
A) Reported MTFs with combat crisis intervention teams.....	45	35.4%
B) Reported MTFs with published operating instructions.....	26	20.4%
C) Reported MTFs with operating instructions outlining wartime psychiatry, psychology, and social work duties.....	16	12.5%
D) MTFs with combat crisis intervention team training every six months.....	34	26.7%
E) MTFs with combat crisis intervention team activated during hospital exercises.....	34	26.7%
F) Social workers who think hospital exercises are realistic (i.e., 20% of "all" casualties are psychiatric).....	10	7.8%
G) Social workers favoring publication of an Air Force-wide operational plan outlining wartime medical roles of all mental health officers.....	125	98.4%

Table 2. Air Force Medical Treatment Facility (MTF) Combat Crisis Intervention Teams: Established Teams and Training

hospital exercises and fewer than 8% of the respondents think hospital exercises are realistic (i.e., 20% of all casualties in the exercises are psychiatric).

The survey statistics suggest a significant void of current programs to deal with combat stress disorders. In addition, the data points out the need for comprehensive operating instructions, well-defined roles for mental health officers, and realistic training. In fact, 98.4% of the population favors the publication of an AF-wide operational plan outlining the roles of all mental health officers.

Part two of the questionnaire sought to reveal information about Air Force social workers' perceived capabilities to manage combat-related stress disorders (see Table 3). Although 74% of the population reported they were familiar with the BICEPS treatment regimen, only 53.5% noted that they were prepared to manage combat stress disorders. In addition, almost 90.5% reported they were interested in receiving further combat stress training. Clearly the statistics indicate a need to develop and maintain combat stress training programs. Many respondents wrote on their survey that "realistic, frequent training is the key in the peacetime preparation for war."

	Frequency of Response	Percent of Total Responses
Total.....	127	100%
A) Social workers who are familiar with treatment regimen "BICEPS".....	94	74.0%
B) Social workers who think they are capable of managing combat-related stress disorders.....	68	53.5%
C) Social workers with actual combat experience, i.e. in a position to receive hostile fire.....	20	15.7%
D) Social workers interested in receiving training to manage combat-related stress disorders.....	115	90.5%

Table 3. Air Force Medical Treatment Facility (MTF) Crisis Intervention Teams: AF Social Workers' Perceived Capabilities to Manage Combat-Related Stress Disorders

Part three of the questionnaire gathered data about the need to educate and train wing and squadron commanders, as well as NCOs and airmen, on combat stress (see Table 4). The statistics show that Air Force social workers believe wing and squadron commanders need to better understand combat stress and its impact on the mission. In addition, 93.7% of the respondents believe NCOs and airmen should receive combat stress training.

	Frequency of Response	Percent of Total Responses
Total.....	127	100%
A) Social workers who think wing and squadron commanders have a realistic understanding of combat-related stress disorders and how they can prevent these disorders.....	7	5.5%
B) Social workers who think wing and squadron commanders need training to identify, prevent, and manage combat-related stress disorders.....	119	93%
C) Social workers who think NCOs and airmen need training to prevent, identify, and manage combat-related stress disorders.....	119	93%

Table 4. Air Force Medical Treatment Facility (MTF) Combat Crisis Intervention Teams: Future Training and Readiness Considerations

In the final analysis, the questionnaire results clearly point out the need to address two fundamental problems. First, senior medical leadership should publish a comprehensive operating instruction outlining the goals, objectives, functions, and tasks of a combat stress treatment team.

The second problem involves realistic, frequent combat stress training for both mental health officers and line commanders. To repeat, 93.7% of the respondents think wing and squadron commanders should be educated on combat stress disorders. The following chapter addresses these two problems by proposing guidelines for establishing a "standardized" combat stress treatment team and training these teams on a regular basis.

Chapter Five

GUIDELINES FOR ESTABLISHING A COMBAT STRESS INTERVENTION TEAM NEAR THE SECOND ECHELON MEDICAL FACILITY: A PROPOSAL

To repeat, military medical history demonstrates that the effective treatment of the psychiatric casualty is contingent upon timely, supportive therapy--provided as close to the battlefront as possible (17:--). In addition, senior Air Force medical leadership argues that the second echelon of medical care is the most appropriate setting for successful outcomes to occur (17:--). In fact, treating the psychiatric casualty as close as possible to the attack area allows medical officers to practice the widely accepted BICEPS treatment regimen.

In view of U.S. war experiences and the success medical officers experienced with the fundamental principles of forward-based treatment plans, it becomes obvious that future medical wartime plans should implement second echelon psychiatric treatment teams. To date, the Air Force medical planners haven't established standardized operating instructions to efficiently and effectively respond to the inevitable psychiatric casualties of war (19:--). Although past medical literature clearly recognizes the benefits of forward-based psychiatric intervention, only small numbers of medical facilities actually have well-defined operating instructions that would assist medical officers to establish psychiatric casualty treatment programs. If war broke out, many Air Force medical officers would find it difficult to establish treatment teams without standardized operating instructions and appropriate peacetime training.

In view of the history and current status of this problem, the author recommends adopting "standardized" medical operating instructions establishing world-wide (S)pecial (P)sychological (I)ntervention and (R)e(I)ntegration (T)eams--"SPIRITs." Although the fundamental purposes of SPIRITs are not unique, adopting one single program (i.e., one identified by the acronym SPIRIT), would provide all medical officers with a common reference point. Also, instead of having a variety of treatment programs, some of which may not even use BICEPS principles, the Air Force medical community should rely on one universal program that could be established in all areas of the world. In short, the Air Force could transfer medical officers trained in the SPIRIT system and expect that they would know how to establish another SPIRIT team or carry on the work of an already established SPIRIT team. Furthermore, identifying a combat crisis intervention team by the acronym SPIRIT would help replace medical terms that suggest to commanders and airmen that individuals

seeking assistance are medically disabled and incapable of returning to their units.

The concept and development of a special psychological intervention team is not new. In fact, the U.S. Navy established a "Special Psychiatric Rapid Intervention Team" (SPRINT) in 1977 (9:133). The peacetime purpose of SPRINT involves responding to natural disasters, ship collisions, and other peacetime catastrophic events. Mental health members of the SPRINT have found that the fundamental principles of combat psychiatry also work with victims of natural disasters (9:133). The response to SPRINT's services by many of the survivors, their families, and those in the chain of command has been very enthusiastic. Since SPRINT's first deployment in October 1978, the team has been activated 14 times for events such as ship collisions and sinkings, terrorist activities, and suicide attempts. SPRINT has provided service to the Marines, Navy, and the Coast Guard. All catastrophies involved deaths, ranging from 1 to 241, and the length of the intervention ranged from 5 to 46 days (9:133).

In addition to providing a valuable peacetime service, the Navy SPRINT is gaining invaluable experience with near-combat environments. If war broke out, the SPRINT could be activated quickly and apply the skills they have already developed. Regrettably, the Air Force does not have a special psychiatric rapid intervention team. Clearly the development of an AF SPIRIT is long overdue and the benefits of establishing SPIRITs become obvious. AF SPIRITs could respond to aircraft accidents, terrorist events, and natural disasters, and practice the fundamental treatment principles outlined by the BICEPS system. Not only would the team be of immediate service to victims, but the exposure to real-life disasters would help simulate near-combat environments. In short, developing and activating SPIRITs in the peacetime environment would better prepare AF medical officers for actual combat environments.

GUIDELINES FOR ESTABLISHING A "SPIRIT" TEAM

At the very heart of any successful military program are well-defined goals, realistic objectives, effective leadership and management functions, specialized work tasks, and proper training (20:--). Most operations, programs, or plans successfully combining these elements typically are capable of building strong, effective teams, unit cohesion, and mission accomplishment (18:--). Building an effective SPIRIT team is no different.

Stated in broad terms, the fundamental goal of a SPIRIT is to provide commanders and NCOs with a system through which they can maintain troop strength, enhance individual dependability, promote unit cohesion, maintain readiness, and improve combat effectiveness. Although other, secondary goals may be identified, SPIRIT members must ultimately concentrate their primary efforts on providing commanders and NCOs with a system that enables them to maintain their fighting strength and effectiveness.

In order to do this, a SPIRIT breaks its overall goal down into objectives, functions, and tasks. Objectives include nothing more than specific statements of the basic goal. Functions further delineate objectives and tasks clearly identify steps to take. In short, objectives, functions, and tasks serve to guide team members from goal development through the action plan stage. As an example, the following chart translates the primary SPIRIT goals into "actionable" objectives, functions, and tasks.

Goals	Objectives	Functions	Tasks
Maintain fighting strength of unit	Return 60-80% psychiatric casualties to unit	SPIRIT intervention	BICEPS treatment regimen
Enhance individual dependability	Build confidence in self/others equipment	Expert consultation	Educate unit on combat stress
Promote unit cohesion	Encourage accurate information/ effective	Expert consultation to commanders NCOs/airman	Educate/ inform
Maintain combat readiness	Train for combat	Expert consultation	Practice combat operations

Table 5. SPIRIT Team Goals, Objectives, Functions, Tasks

Once goals are established and objectives clearly identified, the next step involves setting up an action plan. To do this, team leaders need to assign work functions and tasks to individual team members. Here the team must identify clear lines of responsibility and authority, but they should not be totally bound to one specific function or duty. War experiences have clearly demonstrated that the best-planned operations often are plagued with the unexpected, and improvisation has often carried the day. Consequently, team members must have at least a working knowledge of all the team tasks. As a general rule the team should

encourage flexibility and interchangeability in roles. For instance, after intensive battle, resulting in mass casualties, psychiatrists should be assigned duties caring for wounded airmen while social workers and psychologists care for psychiatric casualties. When wounded airmen are stabilized or evacuated from the 2E facility, the psychiatrist should resume their duties with the SPIRIT. During the psychiatrist's absence, social workers and psychologists should assume both leadership and clinical roles.

SPIRIT STAFFING

The U.S. Army found in World War II and in Korea that there is a relatively constant ratio of one psychiatric casualty to between four and five wounded in action (13:14). Based upon these estimated psychiatric casualty rates, SPIRIT teams should be staffed with adequate numbers of psychiatrists, social workers, psychologists, occupational therapists, and other trained behavioral science specialists.

Ideally a wartime SPIRIT should be staffed with an appropriate mix of health care providers to include the following professions and numbers:

Psychiatrists:	2
Social Workers:	2
Psychologists:	2
Occupational Therapists:	1
Mental Health Nurses:	2
Chaplains:	1
Mental Health Technicians:	3
Total:	13

Table 6. SPIRIT Staffing

Table 6 identifies those professionals best trained to manage combat stress casualties. In addition, staffing the SPIRIT with 13 members allows the team to work in shifts and provide 24-hour medical coverage. Realistically, many peacetime Air Force medical facilities cannot fill all the listed positions. Instead, most facilities should consider incorporating other medical professionals, i.e., physician assistants and nurses, to augment team strength.

SPIRIT LOCATION

Jones states, "The combat-stressed airman should be treated as close to the attack area as possible. It should be within walking distance from the flightline and structurally separated from the 2E Medical Treatment Facility" (11:4). Positioning the SPIRIT team close to the action and away from the 2E Treatment Facility serves two vital purposes. First, it allows the airman's commander and combat buddies to visit him. Jones notes, "Visitation helps to maintain the soldier's emotional bonding to his unit--the strongest factor that sustains people in combat" (11:4). Second, it communicates to the stressed airman that he's not mortally wounded and doesn't require an extensive "medical" examination and treatment.

LOGISTICAL SUPPORT FOR SPIRIT

In order for the SPIRIT to function as a separate treatment facility, adequate shelters, cots, food, latrines, communication equipment, and other supplies should be readily available or "pre-packaged" to expedite the Team's activation. The Base Civil Engineer, Disaster Preparedness Officer, and the Hospital Supply Officer should assume responsibility for logistical requirements and ensure the SPIRIT is supported throughout its activation. Certainly, pre-conflict planning is essential and clear lines of responsibilities must be communicated. The author envisions dedicating the basic supplies of an Air Transportable Hospital (ATH) or similar transportable system the SPIRIT can build and occupy in a short time period.

PEACETIME SPIRIT TRAINING

As history points out, peacetime training often determines success in combat. To further illustrate this point, Colonel James P. Fleming, Medal of Honor recipient, attributed the success he achieved in Vietnam to the hours and hours of flying training he had accrued prior to his entrance into the combat environment (15:--). Colonel Fleming notes, "In the face of crisis, people respond and act according to what they've already learned. You draw upon all the experiences and training you've had and then you put them to work--in spite of the chaos that is happening all around" (15:--). Military history is filled with similar stories of the value of peacetime training. Certainly, training a SPIRIT is no different. An effective SPIRIT should have at its very heart a tough, realistic training system.

SPIRIT training should focus on several different broad and specific aspects of the combat environment. First, all mental health professionals, squadron commanders, NCOs, and airmen need to gain a better sensitivity to the chaotic nature of combat, death, destruction, and unpredictability of war. The author suggests mental health professionals and squadron commanders invite retired or active duty combat veterans to discuss personal war experiences with their units. Guest

presentations add personal perspectives and also provides realism that training films often fail to accomplish. The pool of retired and active duty combat veterans is a vast and invaluable training resource.

More specifically, SPIRIT team members must assume responsibility for additional training at the unit level. Here, training should include buddy care instruction, stress management, and seminars to build and foster greater unit loyalty and cohesion. The significance of unit loyalty and cohesion is of particular preventive value. Most Air Force squadrons, groups, and detachments have combat histories documented at Air University or within base archives. Unfortunately, most airmen are completely unaware that their units were decorated for outstanding achievement or valor during previous conflicts. Commanders and NCOs should bring out their unit history and make unit accomplishments known to everyone (17:--). Such an endeavor would instill greater unit identity, loyalty, and cohesion.

Focusing on hospital training, SPIRIT members should ensure disaster exercises are realistic, tough, and convincing. Specifically, exercise scenarios should include at least 20 percent psychiatric casualties. Twenty percent represents a realistic combat stress frequency and would challenge the SPIRIT's capabilities (17:--). In addition, role-playing casualties should be tutored on how to behave, react, and respond to intervention. Typically, role-playing airmen overdramatize their roles and do not display behavior appropriate to the truly combat-stressed troop. Finally, the SPIRIT should conduct its own individualized training at least monthly. Training emphasis should focus on the BICEPS intervention regime, specific combat duty responsibilities, lines of authority, decision-making problems, and sharing various roles within the team. Every officer SPIRIT member should be capable of establishing and leading an effective team should the situation arise. The SPIRIT must be the focal point for both base and hospital training and education.

As previously stated, the Navy's SPRINT responds to real-life disasters and has proven its effectiveness. The author suggests AF SPIRITs intervene in future natural disasters and aircraft accidents as well. The actual experience of "near combat" environments certainly would enhance SPIRIT capabilities and effectiveness.

Chapter Six

CONCLUSION

Military medical history, at least since World War I, consistently points out that the successful management and treatment of combat-related stress disorders depends on timely, supportive therapy--provided as close to the battlefront as logistically possible. Through years of war experience, the medical community and senior military leaders began working together and applying the lessons learned from previous wars. Today, senior military leaders have begun to recognize the fact that the psychiatric casualty is an inevitable product of armed conflict and the subsequent loss of manpower associated with combat-related stress disorders represents a salvageable resource. In addition, through trial and error, medical practitioners learned that they obtained the best intervention results when working with the psychiatric casualty close to the battlefront and soon after the soldier exhibited signs of mental and physical exhaustion.

Today, Air Force medical officers continue refining the treatment principles laid down since World War I. In fact, the Air Force recognizes the effectiveness of Jones' BICEPS treatment regime and currently applies the BICEPS system in most hospital exercises. Although the military has significantly improved its capability to manage combat-related stress disorders, much more needs to be accomplished. As this paper points out, Air Force medical facilities don't have operational plans providing guidance for establishing "forward-based" psychiatric intervention teams at the second echelon treatment facility. Furthermore, Air Force medical planners haven't clearly defined nor agreed upon the proper clinical roles mental health professionals will assume during war. In order to address these issues, this paper set forth to initially identify current operational problems and then propose options the Air Force might consider implementing. Specifically, the author foresees the critical need to establish (S)pecial (P)sychological (I)ntervention and (R)e(I)ntegration (T)eams (SPIRITs) on a world-wide basis. Such a system not only prepares medical officers for armed conflict, but could be of significant peacetime value as well. One universal intervention team would provide a common reference point for all medical officers and commanders to understand and subsequently apply in both peacetime and hostile environments. Finally, this paper recommends that officer SPIRIT members mutually share clinical and leadership roles during the Team's activation.

In today's world of low intensity conflicts, global world war does not seem necessarily inevitable. Nevertheless, preparation for war

never seemed more important. Peace through strength carries with it the responsibility to maintain an effective, viable force structure and capability to ". . . make the opponent think twice about striking first." It is this peacetime preparation for war that forces the prudent military planner to remember the lessons learned from previous conflicts. The SPIRIT proposal essentially responds to these lessons and provides the Air Force with another tool to better manage the manpower losses of war.

General George S. Patton noted, "Wars may be fought with weapons, but they are won by men. It is the spirit of the men who follow and the man who leads that gains the victory" (1:178).

BIBLIOGRAPHY

REFERENCES CITED

Books

1. Heinl, Robert D., Colonel, USMC. Dictionary of Military and Naval Quotes. Annapolis, Maryland: US Naval Institute, 1985.

2. Remarque, Erich M. All Quiet on the Western Front. Greenwich, Conn.: Fawcett Publications, 1928.

Articles and Periodicals

3. Bourne, Peter G., M.D. "Military Psychiatry and the Vietnam Experience." American Journal of Psychiatry, Vol. 127, No. 4 (October 1970), pp. 123-129.

4. Colbach, Edward M., Major, USAR, and Matthew D. Parrish, Colonel, USA. "Army Mental Health Activities in Vietnam: 1965-1970." Bulletin of the Menninger Clinic, Vol. 34, No. 6 (November 1970), pp. 333-342.

5. Glass, A. J., Colonel, USA. "Psychotherapy in the Combat Zone." American Journal of Psychiatry, Vol. 110 (April 1954), pp. 725-731.

6. Hibler, Russell J., Major, USAF, and Bernard J. Duncan, Major, USAF. "Battlefield Stress Management: Exercises Within the Framework of the Four Echelon Medical System." USAF Medical Service Digest (May-June 1983), pp. 24-27.

7. Hibler, Russell J., Major, USAF. "Battlefield Stress: Management Techniques." Military Medicine, Vol. 149 (January 1984), pp. 8-11.

8. Ingraham, Larry H., Major, USA, and Frederick J. Manning, Major, USA. "Psychiatric Battle Casualties: The Missing Column in a War Without Replacements." Military Review (August 1980), pp. 19-28.

9. McCaughey, Brian G., Captain, USN. "U.S. Navy Special Psychiatric Rapid Intervention Team (SPRINT)." Military Medicine, Vol. 152, No. 3 (March 1987), pp. 133-135.

CONTINUED

Unpublished Materials

10. Erskine, John F., Lt Col, USA; Ann M. Pease, Captain, USAF; and George S. Robinson, Captain, USA. "Medical Operations in Combat." Training handout, Uniformed Services University of the Health Sciences School of Medicine, Department of Military Medicine and History, Bethesda, Maryland, Winter 1981, pp. 6-1 thru 6-9.

11. Jones, David R., Colonel, USAF (Ret). "Combat Medicine: Stress, Fatigue, Morale, and Leadership." Paper presented to annual meeting of the Association of Military Surgeons of the U.S. (AMSUS), San Diego, California, 7 November 1984, pp. 1-19.

12. -----. "U.S. Air Force Combat Psychiatry." Research study prepared at USAF School of Aerospace Medicine, Aerospace Medical Division (AFSC), Brooks Air Force Base, Texas, January 1986, pp. 23-36.

13. Siegel, Arthur I.; F. F. Kopstein; P. J. Federman; H. Ozkaptan; W. E. Slifer; F. W. Hegge; and R. R. Sellards. "Management of Stress in Army Operations." Research study prepared by Applied Psychological Services, Inc., Wayne, Pennsylvania, October 1982, pp. 1-101.

14. U.S. Air Force. "Sampling and Surveying Handbook." Maxwell Air Force Base, Alabama, Air University, 1985.

Other Sources

15. Fleming, James P., Colonel, USAF. Director of Student Operations, Squadron Officer School, Maxwell Air Force Base, Alabama. Interview 8 December 1987.

16. Goldstein, Frank L., Lt Col, USAF. Director, Joint Psychological Operations Course, Hurlburt Field, Florida. Interview 12 December 1987.

17. Jones, David R., Colonel (Ret.). Editor, Aviation Space Environmental Medicine magazine. Interview 12 December 1987.

18. Lester, Kolin, Captain, USAF. Leadership Phase Manager, Squadron Officer School, Maxwell Air Force Base, Alabama. Interview 13 August 1987.

19. Marsh, Royden W., Colonel, USAF. Consultant in Psychiatry to Air Force Surgeon General, Bolling AFB, Washington, D.C. Teleconference 14 August 1987.

20. Traynor, Bernard V., Major, USAF. Chief, Command and Staff Division, Squadron Officer School, Maxwell Air Force Base, Alabama. Interview 10 December 1987.

B. RELATED SOURCES

Books

Goldstein, Harris K. Research Standards and Methods for Social Workers. Northbrook, Illinois: Whitehall Company, 1969.

Menninger, Walter W. Military Psychiatry: Learning From Experience. Topeka, Kansas: The Menninger Foundation, 1987.

Polansky, Norman A. Social Work Research. Chicago, Illinois: The University of Chicago Press, 1975.

Sonnenburg, Stephen M., M.D.; Arthur S. Blank, Jr., M.D.; and John A. Talbott, M.D. The Trauma of War: Stress and Recovery in Vietnam Veterans. Washington, D.C.: American Psychiatric Press, Inc., 1985.

APPENDIX

USAF PSYCHOLOGICAL CRISIS INTERVENTION TEAMS QUESTIONNAIRE

FROM: Capt David L. Herres, USAF, BSC 15 June 1987

SUBJECT: Questionnaire for Social Work Research Project

TO: All Air Force Social Workers

1. In May 1986, Colonel Jenkins outlined the requirement to conduct social work research when selected to attend doctoral programs or Air Command and Staff College. I'll be attending ACSC in Aug 87 and plan to research "The Wartime Role of Air Force Social Workers Assigned to the Second Echelon Medical Facility." To better understand current programs, policies, innovations, and future requirements, I need your help.

2. I've prepared the attached questionnaire which should take you about 30 minutes to complete. Your responses will provide me information on the current status of crisis intervention teams, guidance for the teams, and training available. Please complete the questionnaire by checking the appropriate areas. Since some answers may not be a simple "yes" or "no", feel free to expand your answer in the space provided. Once you've completed your questionnaire, please mail it back to me in the enclosed envelope. As with any questionnaire, a quick reply is especially helpful.

3. If you have any questions or would like to discuss the results of the survey, please feel free to contact me at the following address:

Captain Dave Herres
520 Sheila Blvd.
Prattville, Alabama 36067

HP: 205-361-1129
AV: 875-2126

4. Thank you for participating in this project! The information you provide will help me to understand where I should focus my efforts.

DAVID L. HERRES, Captain, USAF, BSC

1 Atch
Questionnaire

Instructions For Completing Questionnaire

(1) Do not write your name or social security number on your survey.
(2) Please complete the questionnaire by checking the appropriate areas. Feel free to expand your answers in the spaces provided.
(3) Please try to complete and return your questionnaire by 31 July 87.
(4) Again, thank you for participating in this project!

USAF Psychological Crisis Intervention Teams

Note: For the purpose of this questionnaire, "Crisis Intervention Team" is defined as any mental health department/clinic (or) general medical team established to provide for the identification, prevention, and management of combat-related stress disorders.

---

1) Has your medical facility established a "Crisis Intervention Team?"

Yes _____ No _____

(If answer is "no" or you currently are not assigned to a medical facility, skip to question 18).

Comments: _____

_____

_____

_____

2) Has your medical facility published operating instructions outlining the team's purpose and wartime responsibilities?

Yes _____ No _____

Comments: _____

_____

_____

_____

_____

_____

3) If your medical facility has NOT published operating instructions, please identify the sources of your team's guidance concerning its responsibilities.

Hospital Policies _____
Higher Headquarters _____
Self-initiated and directed _____
Other _____

Comments: _____

_____

_____

_____

4) Do your operating instructions or policies outline specific clinical social work tasks and roles you will carry out in time of war? If "yes", identify the tasks/roles.

Yes _____ No _____

Comments: _____

5) Do your operating instructions or policies outline specific clinical tasks/roles for psychiatrist(s) and psychologist(s)?

Yes _____ No _____

Comments: _____

6) If a psychiatrist is a member of your team and war broke out, would your psychiatrist continue his/her duties as a team member or be assigned to care for wounded patients? (Please check appropriate box)

Stays as team member _____
Cares for wounded _____
Both of the above, (e.g., initially cares for wounded then assumes duties with team) _____
Other _____

Yes _____ No _____

Comments: _____

7) Are you a member of your medical facility's crisis intervention team?

Yes _____ No _____

Comments: _____

_____

_____

_____

8) Are (all) military social workers assigned to your medical facility designated as team members?

Yes _____ No _____

Comments: _____

_____

_____

_____

9) If you are NOT a team member, what function(s) would you serve during armed conflict? (Check appropriate area(s))

Security Team _____ Manpower Team _____

Medical Battle Staff Team _____

Mobility Team _____

Other _____

Comments: _____

_____

_____

_____

_____

10) Where is your team chief identified?

Operating Instructions: _____

Hospital Regulation: _____

Appointment Letter: _____

Other: _____

Comments:

_____

_____

_____

_____

_____

11) Who is the team chief?

Psychiatrist _____
Psychologist _____
Social Worker _____
Mental Health Nurse _____
Occupational Therapist _____
Other _____

Comments: _____
_____
_____
_____

12) How many mental health department/clinic members are on your team?

	Number
Psychiatrist(s)	_____
Psychologist(s)	_____
Social Worker(s)	_____
Mental Health Technician(s)	_____
Mental Health Nurse(s)	_____
Occupational Therapist(s)	_____
Occupational Therapy Technician(s)	_____

Comments: _____
_____
_____

13) How many of the following supplement your team?

	Number
Social Actions Personnel	_____
Chaplains	_____
Family Support Center Personnel	_____
Physician Assistants	_____
Other (specify) _____	_____
None supplied _____	

Comments: _____
_____
_____
_____

14) Does your team conduct training sessions?
If you answered "yes" how frequent is your team's training?

Yes _____ No _____

Every quarter _____ Never _____
Every six months _____ Other (specify) _____
Once a year _____

15) Is your team activated during hospital exercises?

Yes _____ No _____

16) Do the nonmedical team members, e.g., chaplains and social actions personnel, participate in hospital exercises when your team is activated?

Yes _____ No _____

Comments: _____

17) In your opinion, are hospital exercise "patient scenarios" in which your team is activated realistic? (e.g., at least 20% of the casualties are combat stress victims?)

Yes _____ No _____

Comments: _____

18) Are you familiar with the treatment regimen identified by the acronym "BICEPS"? [Brevity * Immediacy * Centrality * Expectancy * Proximity * Simplicity]

Yes _____ No _____

Comments:

19) If war broke out today, and you were assigned to a Second Echelon Medical Facility, do you believe you have had enough medical training/experience to manage combat-related stress disorders?

Yes _____ No _____

Comments: _____

20) Have you ever been a member of a unit assigned within a combat zone? (i.e., in a position to receive hostile fire?) If "yes" identify the conflict.

Yes _____ No _____

Korea _____

Vietnam _____

Granada _____

Beirut _____

Other (specify) _____

Comments:

_____

_____

_____

_____

21) Would you like to receive clinical training in the medical management of combat-related stress disorders?

Yes _____ No _____

Comments: _____

_____

_____

_____

22) Would you favor the publication of an Air Force-wide Operational Plan outlining the wartime medical roles and responsibilities of all mental health professionals?

Yes _____ No _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

23) In your opinion, do wing and squadron commanders, at your base have a realistic understanding of combat-related stress disorders and how they can assist in preventing these disorders?

Yes _____ No _____

Comments: _____

24) In your opinion, do we need to educate wing and squadron commanders on how to prevent, identify, and manage combat-related stress disorders?

Yes _____ No _____

Comments: _____

25) In your opinion, do we need to educate the enlisted force (airmen and NCO's) on how to prevent, identify, and manage combat-related stress disorders?

Yes _____ No _____

Comments: _____

26) In your opinion, what basic steps must senior medical leadership take in order to prepare for preventing, identifying, and managing combat-related stress disorders?

Comments: _____

Thank you for completing this questionnaire!